Realizing that the depressed sensorium of the acutely ill patient could prevent complaints of headache, we prospectively observed 34 clinically well patients (aged 4–38 years, mean 17) undergoing LP. These 19 males and 15 females were all on outpatient therapy for tuberculous meningitis, having completed 6 to 7 months of inpatient therapy. During their 2-year anti-tuberculous therapy they were readmitted every 2 months for physical examination, liver function studies and LP. All LPs were done with the patient in a sitting position. A sterile, disposable 18G needle was used (20G for small children) and 8–17 ml of CSF was withdrawn. Patients walked into the room for the LP and walked out. There was no period of bed rest after LP. All LPs were done before noon and the patients assisted with care of other patients afterwards. Patients were closely observed by nurses and physicians for 2–7 days after LP and there was not one complaint of headache, dizziness, nausea, or other adverse symptom. (Supported by NMRDC, NNMC, Bethesda, Maryland, Work Unit No. MR0000101–3037.)

Several reports have suggested that patients with schizophrenia have minimal or no LPH. We would like to suggest that the cultural background of the patient may be a factor contributing to the degree of apprehension about LP and awareness of complications. This in turn will affect the incidence of LPH.

Yours sincerely

M E KILPATRICK N I GIRGIS
M W YASSIN A ABU EL ELLA

12 August 1982

Lymphadenopathy mimicking lymphoma associated with cryoglobulinaemia and arteritis

From Dr M Ingle Wright
Department of Pathology
University of Manchester

Dear Sir, Professor Friedmann's letter (August *Journal*, p 670) and the paper by Slater *et al.* (May, p 346) prompt me to point out that a similar case has also been described from the Mayo Clinic with lymphoproliferative disorder, mixed cryoglobulinaemia and an immune complex mediated vasculitis (Huston *et al.* 1978).

The importance of the case is that the patient (a middle-aged woman) had been followed as a case of Behçet's disease for 13 years with various severe manifestations, developing lymphadenopathy initially diagnosed as lymphoma. They gave other references of importance, one of which (Kaneko *et al.* 1974) is of a 'nasal lymphoma' developing in Behçet's disease, and reports the autopsy findings.

We do not know the true prevalence of Behçet's syndrome in any country. We do know that nasal lymphoproliferative and destructive lesions are rare. These considerations do not imply that the association is causal, only that it might be so.

Strom (1965) reported endonasal manifestations in ectodermosis erosiva pluriorificialis, associated with cold agglutinins, some with mycoplasmal antibodies; two cases of Behçet's syndrome in the series did not, however, show endonasal lesions at that time.

It is hoped that cases with destructive orofacial lymphoproliferative lesions of the type described will be investigated for systemic vascular diseases, immune deficiencies and tissue type HLA-ABC and particularly DR.

Yours sincerely

M INGLE WRIGHT

2 September 1982

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Fournier's gangrene and diabetes mellitus: survival following surgery

From Dr G M Dootson, Dr C W Lott
and Mr C U Moisey
Department of Urology
Royal United Hospital, Bath

Dear Sir, In your July issue (p 530) Slater, Smith and Mundy presented two cases of diabetes mellitus presenting with Fournier's gangrene. They commented that although the association had been noted by Fournier (1883), there were only three such cases in the literature presenting with diabetes mellitus (and ketoacidosis). We report a patient presenting with Fournier's gangrene and previously undiagnosed diabetes mellitus who survived following surgical debridement.

A 71-year-old man with a 2-month history of unexplained weight loss was admitted with a 4-day history of scrotal pain. On examination he was confused, dehydrated and ketotic. His temperature was 36.8°C, pulse rate 100/minute and blood pressure 110/60 mmHg. The scrotum was swollen and very tender and with a necrotic area 3 × 2 cm on its under surface. Investigations showed a blood glucose of 29 mmol/l, bicarbonate 24 mmol/l, potassium 4.5 mmol/l, sodium 128 mmol/l and urea 19 mmol/l. His haemoglobin was 11.9 g/dl, white cell count was 21×10^9/l (94% neutrophils) and platelet count was $249 + 10^9$/l.

He was rehydrated and later on the day of admission the gangrenous area was excised under spinal anaesthetic. Gas and abscess formation was noted in the tissue planes. His diabetes mellitus

was treated with Actrapid insulin subcutaneously and he received benzylpenicillin, gentamicin and metronidazole. Blood cultures were sterile and wound swabs grew a mixture of organisms including *Streptococcus faecalis*, coliforms and betahaemolytic streptococci. Pathology showed acute inflammatory ulceration with virtual abscess formation in the underlying tissue.

The wound was treated with twice-daily baths and dressings and it granulated well. The diabetes mellitus required insulin for 7 days and at discharge he was on diet-control only.

Although no coagulation screen was done, there was no clinical or pathological evidence of a disseminated intravascular coagulation. In the cases described by Slater *et al.*, the presence of disseminated intravascular coagulation in the area of gangrene was a reflection of the widespread changes occurring in a patient dying of overwhelming infection.

We feel that, in comparison with the first case reported by Slater *et al.*, urgent surgical debridement is essential in halting possible overwhelming spread of the gangrene (Jones *et al.* 1979).

Yours faithfully

G M DOOTSON C W LOTT C U MOISEY

2 August 1982

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Effects of acupuncture in bronchial asthma

From Dr Simon Hayhoe
St Mary's Hospital, Colchester, Essex

Sir, Professor Dias in his reply to Dr Marcus's letter (August *Journal*, p 670) remarks: 'Even if acupuncture does release a chemical substance, it is difficult to envisage a delayed bronchodilator action of such a substance . . .'. I must disagree. There are at least two possible mechanisms by which acupuncture could induce bronchodilation in an asthmatic and both of these mechanisms could have latent or prolonged effects which are independent of the position of needles, so that the same results would be expected from both Professor Dias's control and treated groups (April *Journal*, p 245).

Initially the well publicized β-endorphin release (Clement-Jones *et al.* 1980) is likely to give a calming effect with a general feeling of well-being. Together with the endorphin, ACTH is produced (Malizia *et al.* 1979). This, through a release of cortisol, will not only give improvement by its modification of the immune response, but will potentiate any β-adrenergic response by increasing adenyl cyclase activity.

An alternative or additional mechanism is through the action of catecholamines. Acupuncture will accelerate the synthesis of catecholamines and increase their release for utilization (Han *et al.* 1980). There is likely to be a direct β_2 bronchodilator effect together with a secondary effect via the inhibition of histamine release and again an increased activity of adenyl cyclase.

It is not clear how prolonged an effect acupuncture will have on either ACTH or catecholamine release. However, as asthmatics are notoriously active placebo responders, to show a significant response following acupuncture it is probably necessary to demonstrate an improved peak expiratory flow rate both night and morning, with a reduction in its diurnal variation (Clark 1977). This is particularly important when one takes into account the expected euphoriant effect, seen with both ACTH and the endogenous opioids, which may well result in patients claiming a symptomatic benefit.

SIMON HAYHOE

31 August 1982

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History of writing and its relevance in dyslexia

From Mr G Chowdharay-Best
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Sir, Professor Russell's paper (August *Journal*, pp 631–640) is fascinating, and persuasive in its final conclusion; but it seems clear that more cross-cultural studies are needed. Moreover, the account he gives of the history of writing requires modification.

'The development of writing towards its perfected forms' (p 632) is all very well, but begs a number of questions. What is a perfected form? For its purpose, computer 'language' is an improvement on the Graeco-Roman script, but is unintelligible to otherwise literate persons. The Roman alphabet itself is an exceedingly inaccurate way to represent the sounds of modern English: we would not, otherwise, have so many phonetic scripts, nor would the letters 'ough' possess so many phonetic interpretations. Perhaps the most